Family Group Conferencing in Public Mental Health Care

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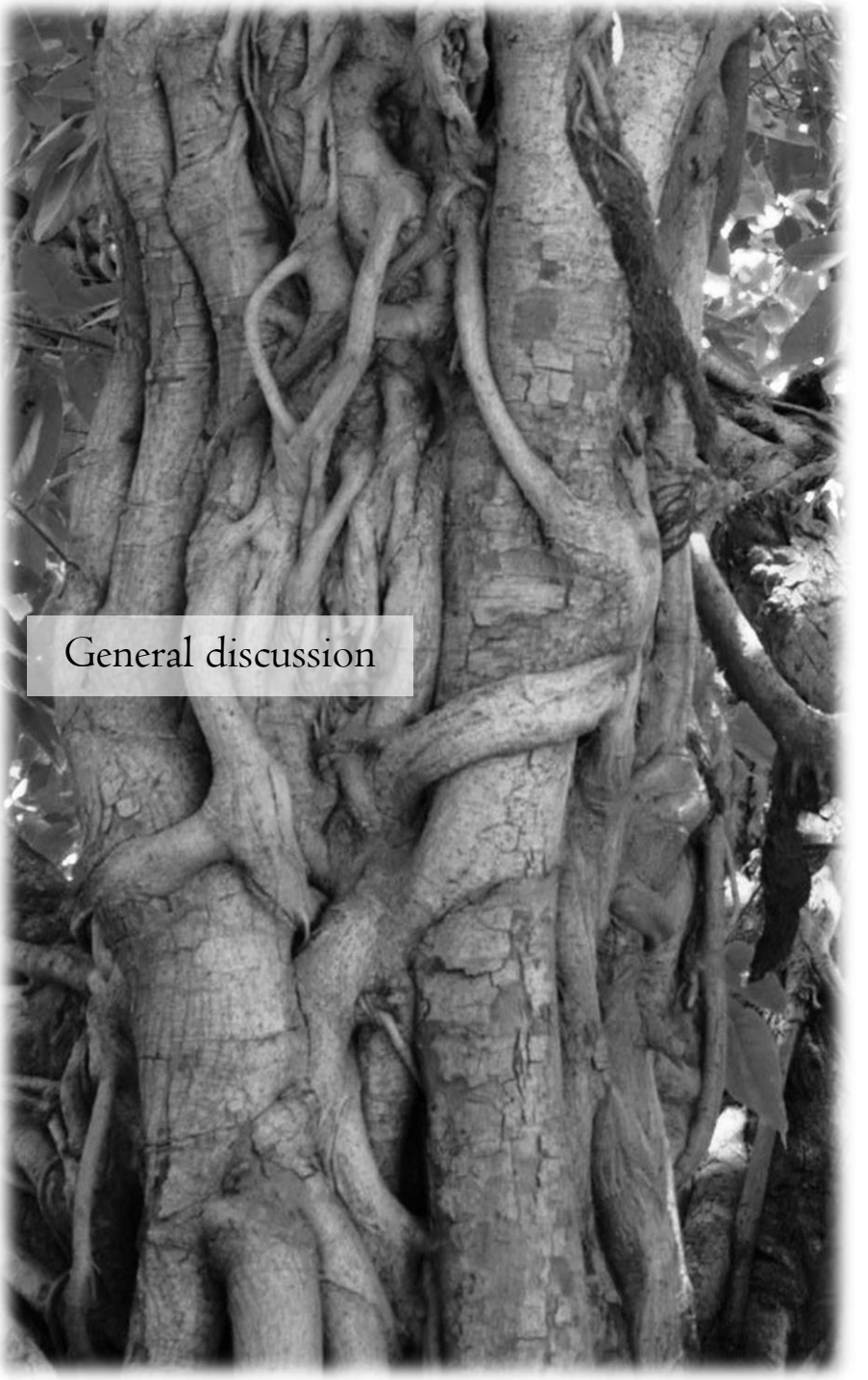

General discussion

Chapter Ten

General discussion

Introduction

In recent years, Family Group Conferencing (FGC) has increasingly become popular in the Netherlands. A growing number of municipalities has embraced this decision-making model as a way for families to get grip on their own lives (Oosterkamp-Szwajcer *et al.*, 2014). In addition, several pilots were or are still being conducted in fields where until recently there was little experience with FGC, such as conferences that are specifically tailored to the needs of older people (Metze *et al.*, 2013), clients with autistic symptoms (HAN, 2013), and families where both parents and children are diagnosed with mild intellectual disabilities (Onrust & Romijn, 2013), but also in situations of imminent housing evictions (HvA, 2008) and financial problems (Oosterkamp-Szwajcer *et al.*, 2014). Not everyone is equally positive about this increasing focus on FGC and there are questions raised about its effectiveness (Bartelink, 2013; Stams & Van der Helm, 2013; Timmerman, 2013). In recent dissertations about professionalisation issues in social welfare, scholars also critically refer to the possible negative effects of emphasising the capabilities of clients and their networks (Spierts, 2014).

The discussion on FGC is not any longer only confined to the scientific arena, but has become part of a wider public debate. In these discussions the underlying values of FGC tend to be overlooked, such as the right to establish a plan on your own before the state intervenes and the importance of an independent FGC coordinator who is free of ties with agencies and who can help bridging the gap between the life world and system world (cf. Van Beek, 2014). FGC is, according to its critics, a hidden means of the national government to cut budgets of social welfare and health care, because if citizens with problems should first rely on their own network there is no need to call in professional help.

Our study focuses on what happens when people who have a history of expropriation and state interference are given the chance to establish with the help of their social network an action plan, including the twists and turns that occur during this process. *Verstehen*, that was the goal of our study (Schwandt, 1999): gaining an understanding of how FGC proceeds in public mental health care (PMHC) – a field with limited experience in FGC – and what this decision-making model can offer to

socially isolated people who have been languishing for a long time, and whether it helps solving liveability problems in neighbourhoods. In this thesis we have led the reader through the complex practice of FGC in PMHC, such as we have gone through the past years. By this we hope to provide readers with a vicarious experience (Abma & Stake, 2001).

Our study consisted of two phases. First, we aimed to analyse each family group conference by a case study design, using responsive evaluation. In a period of two and a half years we had been evaluating the course and outcomes of 41 conferences. Each conference was analysed along the following main question:

How did the family group conference in the given public mental health care setting proceed according to the participants, and what were its outcomes in terms of improving the living conditions of clients, client systems and neighbourhoods, intensifying their social support, strengthening their capabilities, and alleviating the caseload of professionals?

In addition to the individual case studies, we conducted several meta-analyses to provide an answer to the second main question of this thesis:

How can the process of Family Group Conferencing in public mental health care be understood, and which explanations can be given for the perceived outcomes or lack thereof?

The outline of this chapter is as follows. We start with highlighting the main findings of our study and reflecting on them. In the third section we elaborate on methodological issues. The last two sections present suggestions for further research and implications for practice. We conclude this chapter with a general answer to the main research questions.

Main findings and reflections

In this section we sketch five main findings from our study. We deepen the reflection on these findings with the help of insights from the literature.

A faded and broken network as indication for FGC

A prominent result of our study, as presented in Chapter Six, is that social isolation is not a contra-indication, but a reason for organising FGC. Our study indicates that FGC

has the potency to recover damaged and diluted contacts between clients and their social network, so that downward spirals of deterioration can be broken through. This is specifically important to PMHC as a large part of its population finds itself in isolated and neglected conditions.

The first case as described in Chapter Six reveals that even after a conference contact with people who did not participate in it can restore. Several months after the conference was organised, the client got contact again with his daughter who he had not seen for more than seven years. She always loved her father, but as he started drinking excessively after his divorce, eventually becoming addicted and turning into a difficult man, he was not able to fulfil his role as caring and supportive father any longer. She did not want to face the pain and misery that accompanied her father's deplorable circumstances, and therefore decided to cut all ties with her father. When a professional after the conference traced the address of the daughter, contacted her and told that her father became sober and found a way out of his deplorable life, she wanted to give him a second chance. One year after the conference was organised they saw each other again for the first time in years. Not only father and daughter got reunited, the man also met his grandchild for the first time in his life.

The role of shame as engine for prevention emerged in both the conferences on liveability problems (Chapter Three, Seven and Eight) as well as in conferences on marginalised living conditions of socially isolated clients (Chapter Six). Both situations that can be frequently observed in PMHC. In the first situation it mainly involves one or more actors who cause inconvenience to others. Our research findings indicate that FGC holds the potency to provide a platform on which victims feel at ease to reveal their displeasure and the inconvenience they experience with troublemakers, while trouble makers have the opportunity to explain their side of the story (Chapter Three and Eight). In the second situation, clients can explain why they have languished for such a long time, creating understanding among their social network for how they ended up in such deplorable living conditions (Chapter Six). Both of these situations ultimately led to a recovery of relationships and paved the way for a new beginning of meaningful contact with the social network.

Reflections

Several other studies report about the influence of shame in the process of FGC (see among others HvA, 2008; Jackson & Morris, 1999; Merkel-Holguin, 2004; Mirsky,

2003), but none as prominent as we did in our study.[1] Shame was actually a recurring pattern in every case we have analysed.

In the literature it is described that shame can lead to social isolation. An influential study into the concept of shame and its impact on the human condition was done by Donald Nathanson (1994). He described that shame can either drive people to act aggressively towards others or themselves. People can also socially withdraw as they do not want to be confronted with shameful situations. Many clients in our study revealed to us that because of shame, they were avoiding contact with their network. Shame on one side acted as an engine behind withdrawal and avoiding contact with family and friends, but also acted as a catalyst of breaking through deterioration and isolation. Clients told us that FGC provided them a platform whereon they felt at ease to share their shameful feelings. Afterwards they felt relieved. In such circumstances, recovery of contact with the network flourished and consequently the network was more willing to offer its support (Chapter Six).

In Chapter Six we have described how with the help of FGC, downward spirals of social exclusion can be averted. We therefore conclude that a faded and broken network is not a contra-indication for FGC, but precisely a major reason to organise a conference so that shameful feelings can be shared, recovery of contacts can take place and informal support will be mobilised.

You'll change for your mother, not for professionals

Many clients in our study did not want to change for professionals, but were willing to do so for their family, friends, and even former colleagues (Chapter Three and Six). Those loved ones can use words that professionals would (and even legally could) never employ, but that are sometimes needed to convert clients to change their behaviour for the better. We have described in Chapter Nine, however, that many clients did not want to hang out their dirty laundry and prefer the route to professional help where same degrees of shame are not evoked. When professionals choose too easily for individual trajectories, an array of potential solutions is missed. Our findings show that even in the most desperate situations it is justified (to undertake attempts) to mobilise informal resources before individual care plans are made (Chapter Six).

Several of our cases indicate that when the atmosphere at home was so tense and threatening, the organisation of a meeting in a neutral environment with a larger group of bystanders created conditions for progress that could never be reached with

[1] Except from studies that examined effects of family group conferences as a means of restorative justice (see for example Harris, 2006; Umbreit, 2000). This is, however, a different form of conferences in comparison to the ones as organised in youth care, social welfare and mental health care.

professionals. In Chapter Three we have described a case which revealed that the conference, contrarily to the informal meetings at the kitchen table which were organised prior to it, did not have many routes to flee from the pain and suffering that the sons caused to their mother and stepfather. This was so because family members were participating who were not invited for the informal discussions at the kitchen table. Precisely the aunt and stepsister were the ones who were able to confront the sons with their unacceptable behaviour; they had the ability to escalate when they deemed this necessary (eventually in such an extension that the youngest son burst into tears), but who were also able to manage the conflicts in an adequate manner as 'shock absorbers'. The case revealed that confrontation with the misery that has been caused to others is difficult, but that it also laid the foundation for recovery. In this case, shame played an important role after the conference, as both sons did not want to face the grief of others once again and feel the embarrassment that is evoked by the consequences of unacceptable behaviour.

Reflections

One could question the added value of FGC compared to a professional who tries to solve problems at the family's kitchen table. In the Netherlands, these so-called kitchen-table-conversations are increasingly deployed by professionals who on the basis of assertive outreach try to get contact with clients who are hard to reach. During our years of investigation we often heard the question *What is the added value of FGC above a kitchen-table-conversation?* Critique was raised why such a conference should be organised when it is cheaper to discuss and solve problems under the watchful eye of a professional (see Van Dam, 2013).

In a kitchen-table-conversation, the professional aims to clarify the client's demand for care and in addition indicates the self-reliance of the client and the possible support from the social network before it is decided which professional help should be applied for (Bosselaar, 2013; VNG, 2013). There are even particular assertive outreach types of kitchen-table-conversations, such as the 'behind the front door' ('achter de voordeur', Kruiter & Kruiter, 2013) and the 'straight towards its goal' approach ('Eropaf!', Van der Lans, 2010). The aim of both methods is similar: trying to establish contact with and gain trust from multiproblem families and people who are avoiding the care they actually need, detecting their problems in an early stage, and reaching a solution through a dialogue with the family or client in an informal setting, such as at the kitchen table, before problems get so much out of hand and subsequently expensive specialist care is called in.

Social interventions that aim to reach groups who are hard to engage in professional help are increasingly popular. Though, when problems got so out of hand, when the situation is unclear and no one has an overview, when interests collide, or when too many actors are involved who cannot take place at the kitchen table, it is difficult to address and strengthen the client's capabilities by just an exploratory meeting between the client and professional. The case we have highlighted in Chapter Three is exemplary hereof. Who were lacking at the kitchen table in this case, were extended members from the social network who could have confronted the two sons with their unacceptable behaviour. During a meeting with extended family members, it is more difficult for participants escaping from the meeting. It are precisely members from the social network who can speak out words that could never be used by professionals, but that are sometimes needed to let clients realise the misery they have caused to others. Indeed, clients in our cases rather wanted to change for their loved ones than for professionals. It are also the loved ones who could absorb shocks when emotions are getting so intense, and can subsequently prevent the conference from getting stalled.

Further on, we agree with Bosselaar (2013) that an informal exploratory meeting holds the risk that a dialogue between the client and professional never sets in as the professional pushes its own agenda through. The professional is by definition in this situation better informed and equipped than the client, so there is a power imbalance. This is demonstrated by questions clients need to think about before the meeting is deployed, such as (VNG, 2013): *What is this conversation about?*, *Who am I allowed to invite for the conversation?* and *What could be the possible outcomes and can I reject them?* (p. 35). Especially with clients who have a history of expropriation, there is the risk that they have difficulties to express their own wishes in a dialogue with professionals. When clients cannot express themselves, they are often labelled as passive and lacking initiative. Thus, professionals will quickly take the lead resulting in that clients once again will be deprived from taking decisions themselves. The colonisation of the life world by the system world is in such a situation not reduced, but rather reinforced (e.g. Habermas, 1981, 1989). FGC radically breaks with this as it enables clients to become the owner of solutions, rather of just being the owner of their problems (Burns & Früchtel, 2012; Hayes & Houston, 2007). The strength of FGC is that it appeals to clients and their network to establish a plan on their own, while professionals indicate the minimum frames the plan must meet to. Precisely FGC gives back the full responsibility to clients and their network. Professional inform but do not impact the development of the plan.

We further on wander how a professional would get a coherent picture of the social network and the capabilities it has to offer when it is only the client who is being

consulted (e.g. Bosselaar, 2013). As we have observed in our study, clients frequently kept their network aloof because they felt ashamed. FGC could serve as a platform on which clients feel at ease to share their shameful feelings, and consequently contact with their network can recover. A side-effect is that a conference provides the professional a clear picture on the composition of the social network and the support it has to offer.

We can conclude that the complexity and multiplicity of problems in PMHC often requires the involvement of a large group. Precisely FGC creates conditions for recovery of contacts within networks and highlighting the problem situation from all different angles, as all of those involved are invited to participate. In such a sense, an overall solution is easier reached than when individual care trajectories would be organised. Our research findings show that in PMHC the involvement of the social network produces the progress that is needed as loved ones can confront clients with their unacceptable behaviour, consequently let them realise something should be changed.

Preventing coercion with FGC

A condition that could frequently be observed in PMHC, and where FGC has potency, is in the prevention of coercive measures, such as when housing evictions (Chapter Eight) and involuntary admissions to a psychiatric ward are imminent (Chapter Seven).

Although the housing association as described in Chapter Eight in a case on a quarrel between neighbours in a small residential area did not threaten with evicting residents from their houses, it was clear that something needed to be done preventing the situation from getting worse and risking housing evictions in the long run. Neighbours who were already bullying each other for a long time, gathered together in a conference and as the FGC coordinator paid explicit attention to adequate communication (working with so-called communication-circles and a talking-stick) every actor was given enough space to express emotions and grievances, but also possible solutions for the problem situation. Eventually a plan got established where every neighbour agreed on, which had a direct positive effect on the liveability after the conference. Even when we contacted the neighbours and the housing association one and a half year after the conference, they revealed to us that the situation was still stable. As the conflict got solved, it was not necessary for the housing association to execute drastic measures, such as evicting people from their houses (which is usually the case when conflicts between neighbours will continue).

The case as highlighted in Chapter Seven is a good example of the opportunities FGC has in averting involuntary admissions to a psychiatric ward. The client in this case, a man with schizophrenia, had been living in a small neighbourhood for several years without causing significant inconvenience to his neighbours. But as he refused

medication, his psychotic symptoms became worse, and he increasingly started to behave unacceptable, such as decorating the bicycles of the neighbours. Although in his opinion he did his neighbours a favour, his neighbours were less enthusiastic about this 'artistic act'. When they confronted the client with this, he acted aggressively. Finally, they asked his case manager for help who immediately requested an involuntary admission. However, sending the client to a psychiatric ward was not what his neighbours intended; they only wanted to be strengthened on how to deal with him in a proper manner, preventing the situation from escalation. Eventually, the request for an involuntary admission 'created bad blood' among the neighbours, so the contact with the case manager and her organisation became abrasive. A conference was organised to establish a plan with a clear aim to stimulate the neighbours taking the situation in their own hands and to prevent the involuntary admission. The neighbours were helped after the conference by two newly added professionals and the sister of the client. Afterwards they felt empowered and consequently were better able to deal with the client. One year after the conference, the client was still living in the neighbourhood without being involuntary admitted to a psychiatric ward.

Reflections[2]

Averting coercive measures in PMHC such as housing evictions and involuntary admissions to a psychiatric hospital is a major benefit, as consequently the accumulation of negative experiences with professional care will be halted (Bertram & Stickley, 2005; Forchuk & Reynolds, 2001; Frueh *et al.*, 2005; Katsakou *et al.*, 2010; Landeweer *et al.*, 2011; O'Brien & Golding, 2003; Robins *et al*, 2005; Voskes *et al.*, 2013).

Multiple signals often precede an eviction (Schout *et al.*, 2014): rent arrears, unemployment, the inability to build or maintain a social network, disputes with other tenants and neighbours, mental health problems, addictions, and poor independent living skills. This may be further complicated when actors become each other's opponents, when the capabilities of clients are overestimated, when there is a lack of a concerted effort to avoid the eviction, and when professionals do not own the capability to commute between hard and soft. FGC can break through these patterns and consequently avert an eviction. This also applies to the prevention of involuntary admissions. The number of cases where the dark cloud of an involuntary admission hung above a client was however too limited to provide strong evidence for FGC's potency to avert coercive measures in psychiatry.

[2] Some insights in this section have previously been published in a short commentary (De Jong & Schout, 2010).

The study of Van der Post *et al.* (2009) sheds light on factors associated with the decision to admit clients compulsorily to psychiatric services. Remarkable findings from this study were that "physicians were more inclined to decide on compulsory admission for patients with a history of compulsory admission than for those without" (p. 1545), and that "patients who received more intensive outpatient treatment in the year before the consultation were less likely to have an emergency compulsory admission" (p. 1545). This study concludes with the following statement: "to test the hypothesis that outpatient treatment indeed has a preventive effect on compulsory admission, intervention studies are a necessary next step" (p. 1546).

Our research findings brought to surface that there are good reasons for organising FGC to prevent coercion. We have observed that the tapping and mobilising of resources, as described in the literature on FGC, could be seen as an elaboration of outpatient treatment and therefore could play a key role in the by Van der Post *et al.* (2009) emphasised necessity of intervention programmes to prevent coercion. Several studies have indicated that clients suffering from psychiatric diseases benefit from mobilising and strengthening social support (see amongst others Almedom, 2005; Becker *et al.*, 1998; Evert *et al.*, 2003; Giordano & Lindström, 2011; Lim *et al.*, 2014; Mohnen *et al.*, 2011; Panayiotou & Karekla, 2013; Rothon *et al.*, 2012; Strine *et al.*, 2008; Thoits, 2011). In short, people who are socially embedded are less vulnerable (Poortinga, 2006). Our study indicates that FGC can help in restoring broken and faded contacts as both the quantity and quality of social support after the analysed conferences increased (Chapter Five). Although we lack causal relationships, on the bases of evidence from other studies, it is plausible that an increase in social support after the conferences positively affected the resilience of clients (e.g. Becker *et al.*, 1998; Lim *et al.*, 2014; Panayiotou & Karekla, 2013; Strine *et al.*, 2008; Sündermann *et al.*, 2014). With the help of family members, friends and neighbours requests for different forms and stages of coercion like housing evictions, conditional assistance, community treatment order, and involuntary admission can be averted or postponed.

Social embedding in communities of fate

In several analysed cases it is likely that if a conference was not organised, the state would finally have intervened with legal action, paving the road for individual trajectories, even executing coercive measures when deemed necessary (Chapter Three, Six Seven and Eight). We consider this plausible, as in the conferences that according to their participants had failed, professional help intensified afterwards and sometimes forms of coercion were carried out when the client and social network were not able to

come to a solution and subsequently no social support being sustainably mobilised (Chapter Nine).

Can FGC ensure the social embedding of PMHC clients in communities of fate – communities where people are born, raised, and feel belonged (Hirst, 1994) and where the success of individual participants is closely linked with the success of the larger collective (Stinchcombe, 1965)? First of all in our study, it was not FGC in itself that increased social support and strengthened the capabilities of clients. It only created the conditions so self-reliance, communal capacity and mutual strength were able to flourish. Further on, as our quantitative analysis indicates, after the conferences professionals usually remained involved (Chapter Five). This, however, is for the PMHC target group not an unfavourable sign, as learning to have and maintain trust is an important goal in this field of care. We have actually seen that networks frequently motivated clients for professional help who before the conference were avoiding the care they actually needed. In other words, FGC does not always necessarily lead to a reduction in care consumption.

In Chapter Three we have questioned whether FGC can ensure the strengthening of 'strong ties' and the extension of 'weak ties'. In several of our analysed cases we have seen that FGC had a positive effect on restoring bonds with loved ones (strong ties), but widening the circle with weak ties was either not tried sufficiently or difficult to achieve with the PMHC client group (Chapter Nine).

Reflections

When FGC plans succeed then this means that the power shifts from a state agency shifts to the client and his or her network; the colonisation of the life world by strategic action of the system world has then successfully been pushed back (e.g. Burns & Früchtel, 2012; Habermas, 1981, 1989; Hayes & Houston, 2007). In the cases that yielded a plan with sustainable outcomes the power balance between the life and system world had not only been redressed, but also a dialogue was set in motion and a common understanding reached. As clients and their social network managed to make their own plan professionals could stay aloof.

As Pellizzoni (2003) argues, professionals and citizens often have troubles understanding each other. Our study revealed that FGC has the potency to mitigate this. This can be observed in the case we have described in Chapter Seven on the liveability problems in a local neighbourhood caused by a man with schizophrenia. As the relationship between the residents and the case managers of the mental health organisation was abrasive, it was decided to include another case manager. In contrast to the first case manager, this case manager was able to establish a constructive

collaboration with the residents who needed to deal with the behaviour of the client twenty-four hours a day. We can derive from this case that professionals are needed who are capable to work from a community-based approach: professionals who are not only able to build a relationship of trust with clients, but also with the resources from their social network who precisely can prevent clients from further deterioration (e.g. Coffey & Hannigan, 2013; Crawford *et al.* 2008; Lohuis & Beuker [Red.], 2013). Consequently, results are not any longer achieved *in the community*, but precisely *through the community*.

Has FGC the potency to reinforce informal bonds? In Chapter Three we have sketched that a collective sense of belonging, loyalty and solidarity is scarce in modern societies. To survive citizens need a stable cultural environment that alleviates them from uncertainty. Clients in PMHC are usually not sufficiently embedded in social systems. Further on, as Furedi (2004) points out, a market-driven health care system magnifies vulnerability. FGC, however, has the potency to break radically with negative tendencies such as medicalisation and psychologisation as it appeals to the capabilities and strengths of people instead of their incapabilities and weaknesses. FGC addresses the confidence people have in themselves and in their capacity to solve problems together with their social network without interference from professionals. It are clients' loved ones and concerned bystanders who can confront them with their unacceptable behaviour and provide grounds for clients showing their regret and subsequently forgiving them. We have seen in our study that FGC can reinforce the resilience of client(system)s and their network and enlarge the quantity and quality of social support. From that perspective, FGC does not have the potency changing society as a whole, however, it can create conditions at the micro-level for the social embedding of PMHC clients in communities of fate.

The bumpy road to a family group conference – challenges and opportunities

The previous findings reveal that the preparation of FGC in PMHC and the course of the conference itself does not proceed according to a pre-prepared script. Every conference we have analysed was unique and had its specific twists and turns. The process towards a family group conference is dynamic and laden with challenges that need to be overcome. Yet, it incorporates opportunities. FGC coordinators frequently struggled with their role as facilitator (who aim to give clients the power to determine their own life), especially when clients remained passive and the social network kept itself aloof.

Clients frequently acted reluctant towards inviting members from their social network who potentially could have had a major contribution to the conference or with

whom it would have been fruitful to restore contact with. In other words, clients sometimes deliberately excluded people from participating in the conference. Several cases we have highlighted in Chapter Nine indicate that it is unlikely that FGC will produce progress when clients are consistently refusing to invite those for a conference with whom restoring relationships is actually commanded. The analysed cases on liveability problems in Chapter Eight further on indicates that conferences risk to fail when the troublemakers do not take part in it, and especially when they are not informed about its progress.

An underlying pillar of FGC is to empower citizens making their own decisions. FGC coordinators, however, often need to act in an arena of tensions where they are continuously forced to decide whether to facilitate citizens in fulfilling their wishes to include and exclude particular members from their social network for participating in the conference or critically think along with clients and let them reflect on the composition of participants. When the circle of concerned bystanders remains narrow, then the arsenal of potential solutions is limited and clients will once again seek refuge in professional care, as we have argued in Chapter Nine.

In cases where there was the threat of coercion and compulsory measures, it proved to be crucial that representatives of agencies were invited to evaluate the outcome plan of the conference on safety issues (Chapter Eight). This does not only count for those cases in which an housing eviction was imminent, but also when families were threatened with outplacements of their children or when a client risked to be involuntarily admitted to a psychiatric ward if (s)he would continue behaving unacceptably. In the cases where a plan was established and later on implemented we have observed that professionals were not excluded from the process and even contributed to a successful conduct of FGC by sharing their ideas on possible solutions and reviewing the plan on safety issues. These professionals were also easily accessible for FGC coordinators when they needed advice on how to establish contact with clients and their network. Additionally, we have seen that these professionals were supportive towards the FGC model and helped FGC coordinators in the process of making clients not only the owners of their problems, but also the owners of potential solutions.

FGC coordinators sometimes struggled with their role task, the same being true for professionals (Chapter Seven and Nine). For them it was hard to resist the temptation to organise individual care trajectories when FGC plans were likely to fail. That professionals are tempted to take over care is understandable. Often they have chosen for their profession because they want to help others. With the actual policy transformations they are forced to ensure that clients take care of themselves.

Professionals need to share responsibilities and cede power to clients and their social network, and it is understandable they struggle with this process.

In several cases, the impact and the quality of the plan was linked to the role and the position of coordinators (Chapter Three and Six). Their role as independent fellow citizens who were not making plans for families, but empowered them to come up with their own plan, was highly appreciated by clients, their network and professionals (Chapter Six, Eight and Nine). FGC-coordinators were easily accessible, even during evenings and in weekends, and they had a non-judgemental mentality towards the situation. They often fulfilled the role clients actually wanted their care providers should have fulfilled (Chapter Nine). Many of the cases we have analysed indicate that clients who had a troubled history with representatives of the professional society, had less trouble with representatives of the civil society. As coordinators were seen as independent and free of ties with agencies, they could also use words that could never be used by professionals (Chapter Three). Also a personal 'click' between coordinators and clients appeared to be important in the cases we have analysed. We hark back to the case we have described in Chapter Six on the man in his sixties who had been addicted to alcohol, who was living in isolated circumstances and who had been languishing for a long time. From the first moment there was mutual trust between the client and the coordinator, probably also as there was a minimum age difference between them. In other cases it was striking that if there was no click or when coordinators did not collect feedback on their own performance, the chances for a successful conduct of the conference and sustainable outcomes decreased.

In nine of the 41 analysed cases it never proceeded from the preparation stage towards the actual conference (Chapter Nine; cases 3, 10, 14, 18, 19, 20, 24, 25, 40, Case overview table in Appendix I). In 30 other cases that were not included in the group of 41 conferences, we have seen that it even never progressed further than a preliminary meeting between the client and FGC coordinator, mainly cases where drug addiction or psychotic problems were on the foreground. We cannot draw firm conclusions why in these cases the FGC cycle never progressed beyond the referral and the first exploratory meeting with the coordinator. We simply lack empirical evidence for this. Still, on the basis of discussions we had with the regional manager of the 'Eigen Kracht Centrale' during our weekly meetings, we were at least able to get an idea on why conferences were cancelled at such an early stage. In several cases, clients who were addicted to drugs had a volatile lifestyle. Professionals had difficulties with making and maintaining contact with this client group, and even struggled with how to achieve any significant progress. Often these clients were referred to a conference when all other solutions had dried up, under the guise of *Let's try FGC, everything else did not work*. It

is a challenge for professionals and FGC coordinators to motivate this client group for a conference, to maintain their motivation and to prevent them for relapse into destructive behaviour of substance use during the preparation towards the conference.

Another challenge for FGC was when a possible conference evoked so much fear that clients were likely to decompensate. This we have seen in cases that centred around clients with psychotic problems. As we have portrayed in Chapter Seven, when it is likely that a conference will aggravate problems the focus of the conference could be shifted: not any longer the client is the main actor of the conference, instead the social network becomes the central party of the conference – family members, friends and neighbours, for example, want to be strengthened and supported on how to deal with difficult and unacceptable behaviour of the client.

Eventually, the success or failure of a conference seems to be situated in three core factors, namely if:

1. enough social capital is mobilised;
2. reciprocity is fuelled, and;
3. professionals are aware of their new task and prevent clients from falling back into individual care trajectories.

If just few loved ones (strong ties) take part then the social emotional support where the client could rely on remains too limited. If no outsiders and concerned bystanders (weak ties) participate, a conference lacks creative angles on possible solutions and consequently it would be difficult to achieve real progress. We have seen that when clients are unable (or even unwilling) to invest in reciprocal relationships, the social network soon gives up, and clients once again seek refuge in professional care (Chapter Nine). Precisely professionals can help preventing this from happening, as they can fuel their client's sense of reciprocity and keep the social network on the right track when the plan is not being implemented according to where everyone agreed on.

Reflections

In such a dynamic practice of organising FGC in PMHC, it is important to find out "what works and what does not work under a range of different conditions" (Weiss, 1997, p. 52), while further attention should be paid to how the intervention works (Rogers, 2002). In Chapter Nine we have elaborated on the apparently failed conferences. These were the cases that according to several participants had failed. Partly because during the preparation of the conference it run aground due to conflicts within the network or because the motivation of the client waned. But also because the

conference itself got out of hand or that the plan was afterwards never or incompletely implemented.

The success or failure of the conferences depended on the extent to which the conferences were implemented according to the FGC model and the degree in which effects such as breaking through social isolation, reducing conflicts, mobilising social support, and alleviating the caseload of professionals occurred. Several cases from our study suggest that a successful implementation of the FGC model does not necessarily lead to desired results (see cases 2, 6, 7, 13, 22, 26, 37, Case overview table in Appendix I), while in two other cases desired results were achieved although the conferences were not implemented according to the FGC model (see case 24, 28, Case overview table in Appendix I). Positive results were even achieved in a few cases where it never came to a formal conference, as for example contacts within networks recovered during the preparation stage and informal support was already offered before the conference was organised (cases 3, 19, Case overview table in Appendix I).

One of the most striking patterns in the family group conferences that according to their participants had failed, was that a single conference alone did not create the progress that was needed. Even when contacts recovered during the process of the conference, they still remained fragile, so when conflicts after the conference broke out once again or the client remained passive and lacked a sense of reciprocity, then the social network quickly threw in the towel. This was also indicated in a Norwegian study that examined the outcomes of FGC for people receiving long-term social assistance. Shortly after the conferences, social support for the clients increased and therefore also their perceived wellbeing (Malmberg-Heimonen, 2011), while after a longer period this support waned as reciprocity was lacking (Malmberg-Heimonen & Johansen, 2013).

We conclude this section with the following remark. Whether FGC helps or not, we consider it paramount that clients should have a say about their fate. Even when clients do not want to join a conference (such as the client as described in Chapter Seven), they should still have to be given the opportunity to make this choice themselves.

Methodological issues

In this third section we concentrate first on the methodological challenges when examining whether family group conferences succeeded or failed. In the following, we reflect on the general limitations of the study project, and the limitations specifically concerning the qualitative and quantitative methods. Additionally, we pay attention to the strengths of our study, namely helping others to understand the process of FGC in

PMHC and the twists and turns that could happen. Here, we use insights from the philosopher Richard Rorty (1991), with his pragmatic view on the 'truth is that what works', as we aimed to construct portraits of individual cases that are simultaneously convincing and inspiring. In such a study as ours, the researcher is the lens through which the reader can gain an understanding of life experiences. As another philosopher, Hans-Georg Gadamer (1960/2004), proposes, a researcher is always subjected to prejudices. We therefore critically reflect on our own role as members of the research team and our prejudices that could have affected the study outcomes.

Examining when conferences succeeded or failed

When an intervention is examined, a distinction should be made between what Rogers (2008) and Stame (2010) call simple and complicated interventions. An intervention is simple when a single actor is doing its implementation according to a standardised plan. The more actors become involved, the more complicated the intervention gets. Given the many actors who are usually involved in a family group conference and their influence during its process, the FGC model is multidimensional, and thus we can characterise it as complicated. Although the conferences analysed in this study followed the four-step FGC model, we have seen that every conference had its certain twists and turns. These were an indication for the adaptation of FGC to the specific needs of those involved in the case. FGC in PMHC was thus far from an intervention with a standardised course. Therefore, FGC was also a complex intervention with multiple layers. The outcomes that FGC generated differ per case. Whether a conference succeeded or failed should be analysed per case. We were aware that a one-dimensional approach would not do justice to the multidimensional nature of FGC. Hence, in our study we have analysed the process and outcomes of each conference from different angles, involving respondents from four stakeholder groups (main actors/clients, members from the social network, professionals, and FGC coordinators).

Before we started our research, we did not have a clearly defined theoretical framework. We had the assumption that the embedding of PMHC clients in social networks would reduce their vulnerability. How this precisely could happen, was a question which we were only able to answer when our study proceeded. The insights from the social capital theory and the role of shame as the engine behind the downward spiral leading to social isolation, but also as the way to escape from it, only gradually came to the surface. The lack of a tightly defined theoretical framework made our study not initially a theory based evaluation (e.g. Rogers, 2007; Stame, 2004; Weiss, 1997). Though, before the first case study was carried out, we had a clear view on how the implementation of FGC would happen, namely according to the four-step model as

described in the literature on FGC (see Hayes & Houston, 2007). Our study was therefore at the start a programme based evaluation. After each case study we gained a better understanding of the theoretical foundations underlying a successful or failed conduct of FGC in PMHC, especially because respondents themselves gave us valuable clues on why conferences had succeeded or failed. Thus we gradually incorporated more theoretical ideas, making our evaluation study eventually both programmatic and theoretical driven.

To determine whether a conference was successful or had failed, we simply asked every actor who participated in the conference the question *Was the conference successful, and why (not)?* It is striking that when the quantitative data are considered, that for the entire group of 41 cases the living conditions improved, client(system)s were strengthened and both the quantity and quality of social support increased (Chapter Five), while the qualitative data led us to more critical conclusions (see especially Nine). Judging from the qualitative data, it can still be concluded that slightly more than half of the conferences were successful.

General limitations of the study project

Working together with student couples had its advantages and limitations. As more than 40 student couples had helped us carrying out 41 case studies, it was possible to reach every participant for an interview. We were therefore able to conduct 312 semi-structured interviews with an average length of 60 to 90 minutes, and organise 41 group member checks. Without the commitment of these students, we would not have been able to carry out this study at such a large scale. The limitations were mainly located in the interview skills of the students and their experiences with and capabilities of analysing qualitative data. This was captured by the research supervisor who managed the whole research cycle of the project. During their case study, each student couple had been guided intensively through the whole research process.

Not every participant of the analysed family group conferences wanted to participate in this study. The absence of their insights negatively impacted the validity of our findings. Nevertheless, as in almost every case we were able to capture the perceptions of various stakeholder groups (main actors, their social network, professionals and FGC coordinators), it was possible to provide thick descriptions of how the conferences proceeded and to describe their outcomes. Further on, in addition to the individual interviews, we organised group member checks that had a specific aim to validate findings from the interviews by letting participants of the conference reflecting on them (Guba & Lincoln, 1989).

The various case studies have a strong ecological validity, that is to say that the qualitative and quantitative methods were aligned and connected with the field of research so that real-world phenomena could be articulated (e.g. Schmuckler, 2001) – in the case of our study: the process and outcomes of the 41 family group conferences. Because the student researchers had an eye for gaining trust of the respondents, they created conditions wherein the respondents felt at ease to share their perspectives. This, however, also had an impact on the reliability of the study results; mutual trust and strong bonds between respondents and researchers influences the extent to which researchers objectively gather and interpret data. This was captured in each case study as: 1) the conference was gathered along a standardised topic list (see Appendix II); 2) the interviews were recorded and later on transcribed verbatim; 3) the interviews and analysis of interview findings were co-checked between the student researchers and research supervisor; 4) memos were tracked on specific twists and turns during the process of data gathering and analysis, and; 5) interim findings were validated during a group member check (e.g. Guba & Lincoln, 1984; Silverman, 2013).

Limitations of the qualitative analysis

In each case study we aimed to do all interviews within a period of one to three months after the conference. This, however, in practice was not possible. In some cases, interviews took place earlier, while in other cases interviews were done a few months later than actually planned. It was a continuous tuning between the number of cases that could be analysed and the student couples who were so to say 'in stock' and able to carry out the case study. The practice of FGC in PMHC proved to be complex and multi-layered. Of the around 70 referrals, 30 cases never progressed beyond an exploratory conversation between the client and FGC coordinator. In these cases we have observed that clients, who initially agreed to a conference, were afterwards difficult to reach for both FGC coordinator and professionals, especially in cases of drug addiction. Sometimes a conference evoked so much fear or aggravation of psychotic problems that it was not possible to proceed with it. Of the 41 cases eight conferences became stuck during their preparation and never progressed towards the actual meeting. Some others of the 41 cases led to the meeting, but as conflicts broke out, they were abruptly cancelled and did not deliver plans. It is somehow understandable that researching such a practice required a lot of skills, patience and tact of students. We are still positively surprised by how these students were able to make contact with and gain trust of this client group and were able to take away resistance.

Coming back to the period in which interviews were done. It was precisely our aim not to wait too long evaluating the process of the conferences as when respondents

needed to look back several months after the conference they had difficulties describing what really happened. On the other hand, it was easier for them to reflect on the long-term outcomes of the conference. So both had its pros and cons.

Achieving substantive saturation in this type of research is an indication for methodological quality (Guba & Lincoln, 1989; Guest *et al.*, 2006; Small, 2009). Our intention was to continue interviewing until no new themes and labels would emerge. In this we partly succeeded. In the analysed conferences, we have seen certain patterns coming back regularly, both in the successful conferences as the apparently failed once. The paradoxical effects of shame is hereof the best example. We can therefore conclude that we reached a certain level of saturation in our meta-analyses. On the other hand, whether FGC can prevent coercion in psychiatry requires further investigation. The cases wherein there was the threat of an involuntary admission to a psychiatric ward, were too limited to draw firm conclusions about the evidence of FGC as a means for the reduction of coercive measures (cases 29, 33, Case overview table in Appendix I). The case as described in Chapter Seven, however, indicates FGC's potency in doing so.

Is it possible to generalise from the several case studies we have carried out? According to Flyvbjerg (2006, p. 227),

> […] that knowledge cannot be formally generalized does not mean that it cannot enter into the collective process of knowledge accumulation in a given field or in a society. A purely descriptive, phenomenological case study without any attempt to generalize can certainly be of value in this process and has often helped cut a path toward scientific innovation.

We do not claim universal knowledge, however our qualitative study reveals how FGC in PMHC proceeds. It therefore holds exemplary value which is context-bounded; in that sense, practices with similar contexts could extract lessons from our study when organising FGC (Abma & Stake, 2014).

Limitations of the quantitative analysis

To establish a dataset from findings of the case studies, we had to gather data from 41 reports. It was especially difficult to derive quantitative data from the reports that were written in the period January-December 2011. The research project was also a process of learning, developing, and improving the research methods and content of the case study reports. After one year, we had better ideas on how findings should be reported and thus it was easier to detect data from the reports that were written after January 2012. Therefore, in 33 of the 41 cases we were able to extract meaningful data. In the other eight cases, for various reasons, no quantitative scores were obtained as, for

example, respondents lacked a clear picture on the outcomes of the conference or there were too few respondents in order to give a reliable indication of the outcomes. Nevertheless, in the 33 cases we obtained scores from 245 respondents on the basis of (one or more of) the scales on the four general outcome measures. The outcome measure 'alleviation of the caseload of professionals' caused problems during the interviews. Many respondents did not know exactly how the scores on this outcome measure should be interpreted in order to give their view on if the conference had an impact on the caseload of professionals. As a result, for this outcome measure there are many 'missing values' leading to an unreliable picture of the workload of professionals.

This study may suggest that individual scores were obtained both prior and after the conferences. That was not the case. We asked respondents during a single interview session that was carried out within one to six months after the conference to reflect on if an increase or decrease in the four outcomes measures was perceived. A limitation of this method is that this could have increased the risk of scoring for positive changes. We have tried to capture this by not just taking the given scores for granted and, in accordance with insights from the solution-focused approach (see Bannink, 2007), we asked respondents to formulate arguments why they indicated an increase or decrease after the conference. Gathering data retrospectively on outcome measures also led in a few case studies to recollection bias, because respondents had difficulties with giving a score to the situation prior to the conference as this meeting got organised a long time ago (six or more months). Another limitation is that the scales on which scores were obtained have not been tested whether they yield valid and reliable outcomes, such as the Health of the Nations Outcome Scale (HoNOS) which is increasingly used in mental health settings to obtain an overall view on mental health problems of clients and their social functioning (Wing *et al.*, 1998; Mulder *et al.*, 2004; Mulder *et al.*, 2014). The scores on the outcome measures of our study were self-reported perceptions; they were not based on objective, measurable behaviour. However, in our opinion, the scales we have used still provided a reliable and valid picture of the four outcome measures, especially as we asked every participant of the conference to reflect on its outcomes. The diversity of perceptions provided not only a congruent picture on the outcomes of the individual conferences, but also on the outcomes of the 33 cases together which we have analysed with inferential statistics.

The number of respondents who reflected in these cases was large, namely 245. This means that on average in each case 7.24 respondents reflected on the outcomes of the conference. The number of cases in our quantitative study is, however, too limited to generalise findings to the entire PMHC population; more and varied cases that reflect the diversity within the population would be desirable. Nevertheless, with 245

respondents who reflected on the outcomes of 33 conferences, we can conclude that the perceived living conditions, resilience and social support of PMHC client(systems)s and neighbourhoods which are characterised by conflicts wherein PMHC clients are involved, had been improved.

Strengths of the study project

The aim of our study was not to *prove*, but in line with Richard Rorty (1991) to *understand*. Therefore, also our quantitative findings help to understand the course and outcomes of FGC in PMHC. We elaborate below further on Rorty's hermeneutic.

As we have described in Chapter One, we have used Stake's (1995) case study approach where the truth is considered relative – what is truth depends on the individual perspective. The truth is not objective, but is according to Stake socially constructed and therefore intersubjective. In other words, a shared reality is shaped through social interactions. Meaning and perceptions are contextual. In the eyes of Stake, assigning meaning is therefore based on where you are at a certain moment, with whom you live and work together, and your living conditions. These thoughts come close to Rorty's view that language and vocabularies represents the social reality, and that these are based on the environment where actors are at a giving time.

In our study, we gave voice to all participants of the conference to describe in their own words (language and vocabulary) how the conference proceeded. Second, we do not claim providing a 'window on the reality or the truth', or, as we have stated before, claim universal knowledge. We aimed to do justice to the individual perceptions of reality of those respondents being interviewed, as well to a shared reality of how the world works according to several respondents (intersubjectivity). By applying grounded theory we were able to disentangle their perceptions so shared realities in various stories were brought to the surface. Thus, we found deeper layers of meaning, imaging why FGC in a specific PMHC case did work or not. In other words, we tried to understand the social reality of participants who took part in a family group conference through their own words and vocabularies. We were finally able to sketch life portraits that were, to speak in the words of Rorty, not only reliable but above all convincing.

A Gadamerian reflection on the role of the research group

According to Hans-Georg Gadamer (1960/2004), unprejudiced *Verstehen* is not possible. It is precisely because of certain prejudices that we are able to interpret the world surrounding us. Prejudices are influenced by the context in which we grew up, they come "down to us from the past or [are] handed down from the past" (Weinsheimer & Marshall in translator's preface, Gadamer, 2004, p. XVI). Prejudices

are based on and changed in an ongoing conversation, which Gadamer describes as *Überlieferung*, best understood in English as 'tradition'. Central in Gadamer's work is investigating the nature of *Verstehen* and its close connection with *Verständigung* (coming to an understanding with someone, or coming to an agreement with someone) and *Einverständnis* (understanding, agreement, consent) (Weinsheimer & Marshall in translator's preface, Gadamer, 2004, p. XVI). People do understand each other, when they have a common understanding on a certain phenomenon. They search for validity in the understanding of the other. If they recognise validity, they will embrace the perspective of the other and consequently will change their own understanding. Underlying coming to an understanding is language – the medium which provides common ground.

Someone can only achieve partial truth; a comprehensive overview of the whole truth is simply not within reach. An interpretation is successful when all the parts of the interpreted phenomenon fit together. A successful interpretation is also time-proof, as when time passes by there is no doubt on its veracity. On the other hand, prejudices are subject to change, so that after a while observations done in the past will be interpreted differently. Important here is that the researcher has the capacity to critically reflect on its own prejudices and does dare to put them at stake.

The research group consisted from the start of Gideon de Jong (research supervisor and author of this thesis) and Gert Schout (project manager). In November 2012, Tineke Abma was added as first promoter of the PhD study. The addition of Tineke as third team member ensured a critical reflection on the research methods and the results obtained so far. Tineke, as a peer reviewer, prevented the group from pitfalls.

We were constantly aware that the rigour of a study such as ours depends greatly on the interpretative skills of the researchers themselves. It was a challenge to provide a reliable picture of how the 41 conferences proceeded. In the words of Flyvbjerg (2006), our study risked "a bias toward verification, [which is] understood as a tendency to confirm the researcher's preconceived notions, so that the study therefore becomes of doubtful scientific value" (p. 234). In line with Gadamer (1960/2004), the research supervisor and project manager of the research group were not free from prejudices. The underlying philosophy of FGC, namely to give people the right to establish first a plan on their own and thereby stimulating their self-determination, we fully endorse since the start of our project; we both somehow are averse to interference from others. Such a prejudice can easily lead to a focus on the positive aspects of this decision-making model, being blind to its drawbacks. To tackle this issue, we paid explicit attention to the conferences that were identified by its participants as having failed (see Chapter Nine).

Suggestions for further research

This section should not just be seen as a free call for 'more research'. FGC has been studied from all possible angles during the last twenty years. With suggestions for future research we focus on FGC in PMHC. We make a distinction between angles that can be studied within qualitative (suggestion one and two) and quantitative designs (suggestion three).

Careful monitoring when organised in other regions

FGC in PMHC is still in its infancy, and it is therefore required to accompany the implementation of FGC with careful monitoring, particularly beyond the context studied here. We assume that when FGC is deployed in an urban area, such as the Randstad (the area in and between Amsterdam, Utrecht, Den Haag and Rotterdam), it will yield different outcomes than the ones as deployed in the city of Groningen and its surrounding rural areas. In the practices in Groningen, we have seen in several cases that even when contacts were so diluted or damaged and clients consequently found themselves back in isolated circumstances, the social network was still willing to gather in a conference as they were not living at large distances. The question is whether this would also be the case in the urban areas in the Netherlands.

Our qualitative study brought various patterns to the surface that help understanding how FGC in PMHC proceeds. It is interesting to investigate whether these patterns would also emerge in other PMHC networks, and specifically the potency of FGC to prevent coercion in psychiatry.

Investigating the role of FGC coordinators and their collaboration with professionals

An area that requires further investigation is the specific role of FGC coordinators in organising conferences for the PMHC target group. We know from our findings that their independent role as fellow citizen was highly appreciated by clients and their social network. Future research should focus on coordinators systematically collecting feedback on their own performance, and whether they adjust their own actions on the basis hereof (feedback loops). It is interesting – taking back into account the withdrawing government and the transformation of the welfare state into a participation state (Troonrede, 2013) – to investigate the collaboration between FGC coordinators and PMHC professionals and how to motivate 'the intangibles' (those who are difficult to motivate for a conference and maintain their motivation during the preparation stage) for a possible conference. This requires a study design that is inherited from the action research methodology (Boog *et al.* [Eds.], 2008; Reason & Bradbury [Eds.], 2001). We

recommend that when such a study would be deployed that the various stakeholders will play a prominent role in the evaluation and optimisation of this decision-making model.

A final topic that could be evaluated within a qualitative research design is the role of professionals and their perspectives on FGC. It is interesting to investigate whether they are willing and able to switch from a *professional driven* to a *family driven* approach (e.g. Merkel-Holguin, 2004).

Outcome measurements

In a commentary that is currently under review at the British Journal of Social Work (De Jong *et al.*, n.d.), we sketch several contra-indications for evaluating the impact of FGC by randomised controlled trials (RCTs), such as the difficulties to control the circumstances where the intervention is implemented and the usually small sample sizes of RCTs that will not yield real significant evidence (see also De Jong *et al.*, 2014). We therefore do not advise measuring outcomes by an RCT where clients within the same region are blindly assigned to a conference or not. If there are scholars who are stimulated by our study to provide 'hard' evidence for the effects of FGC in PMHC, we recommend to compare regions where FGC for PMHC clients are deployed as first legal measure with regions where professionals intervene in a traditional way. In order to achieve meaningful results, we propose to work with large representative samples, such as the study of Wang *et al.* (2012) in which the effects of 7,986 families who took part in a conference were examined in comparison to 72,704 families who received a more traditional form of professional help.

Implications for practice

Our research was dominantly a practice-oriented study. In addition to suggestions for future research, we provide implications for practices. We outline how the FGC model could be adjusted to the needs of the PMHC client group without losing its core values. We make suggestions for FGC coordinators to optimise their own performance. We conclude with implications for professionals who will be involved in future conferences.

The need for follow-up meetings and fuelling reciprocity

A single conference is in many situations not sufficient enough to achieve real progress with the PMHC client group. In several cases we have seen that the positive energy which was set in motion by a conference was easily lost, as the social network quickly withdrew when they sensed a lack of reciprocity. Malmberg-Heimonen and Johansen

(2013) noted the same tendency in Norway in their FGC study. This study had a similar target group, namely clients who had relied on social assistance for a long time. Following implications from this study, we also recommend that in PMHC follow-up meetings will be organised. We have observed in our cases that the principle of organising an evaluation meeting within two months after the conference was often not realised. At the end of the conference participants and coordinator too soon assumed that the client and his or her network would take the lead in implementing the plan. In several cases we have seen that this did not happen, while participants when asked about it during our interviews, addressed the necessity of a follow-up meeting.

The Dutch FGC organisation has explicitly chosen to work with volunteer coordinators who are not bound to care organisations. Our study shows that the independence of FGC coordinators is a great advantage in PMHC. Voluntarily organising these conferences implies a strong commitment of coordinators to the community. Yet, this involvement also has its limits. We cannot expect that coordinators will have a long term involvement with particular clients, and organise several meetings during this period. We address here the opportunities that are reserved for professionals. The professional could be the designated person to prevent clients from relapsing into old patterns, and support and motivate the social network. That also means that they have to make their clients aware of the importance of reciprocity; this starts with the most basic expression hereof, namely the simple words 'thank you' when services are rendered. This also implies that professionals regularly organise network meetings where participants can evaluate the past period, have the possibility to share their shameful feelings and dissatisfactions, and subsequently can focus on the future once again.

Recovery of relationships and expanding life worlds

Perhaps more paramount than when FGC is organised in child welfare; recovery of relationships within a social network plays a crucial role in PMHC. Contacts that are damaged or diluted can actually be strengthened after a conference. One should, however, expands the scope when contacts are not willing to participate in a conference. In such a scenario, it is advisable that FGC coordinators and professionals focus on building bridges to other networks by involving, for example, neighbours and volunteers in the process. These concerned bystanders can come up with creative ideas on how to solve problems. Considering the PMHC client group, it is wise that coordinators would both help in restoring contacts and mobilising potential new resources.

Strike while the iron is hot

The preparation of a conference takes normally four to six weeks (Van Beek & Muntendam, 2011). Such a long preparation has the advantage that the network can be mapped so there will be a clear view on those persons who can and are willing to contribute to a conference. The long preparation time also enables the planning of the conference at a time that suits most of the potential participants best. However, there is also a downside. A substantial part of the PMHC client group has a volatile lifestyle; clients easily lose motivation for a conference. When coordinators not proceed delicately, then clients can abruptly break contact; phone calls and e-mails are not answered, clients no any longer open doors or even treat the coordinator in a not so friendly manner. During the preparation stage conflicts between clients and their network can get so out of hand that the conference gets stalled. We therefore recommend that the coordinator should 'strike the iron while it is hot'. This means that when there are signs for a possible cancellation, then it should be decided to organise the conference in an earlier stage. In this meeting it may be then decided to invest in organising another conference in the near future where the entire social network can take part. This requires that FGC coordinators are sensitive for these signs and, if the situation requests it, would deploy the conference earlier than planned.

Systematically collecting feedback and building specific competences – forms of unwanted professionalisation?[3]

FGC coordinators are crucial actors in carrying out conferences as they are the ones who create conditions where the empowerment of clients and their network can flourish (Natland, & Malmberg-Heimonen, 2013). The coordinators who were involved in our research project frequently struggled with their role as independent citizen. For them it was difficult to find the right balance between remaining the neutral actor who does not judge clients *and* offering them help when they deem this necessary. The independence of coordinators is constantly challenged, for example when they end up in a delicate position as clients entrust confidential issues to them and they have assured clients not to share these with their network or professionals.

To meet the recommendations we have sketched above, we bring in another valuable insight from the literature, namely that of professionals who systematically collect feedback on their own performance (Baert, 2011; Hermanns, 2008; Lambert & Shimokawa, 2011). We assume coordinators would benefit from this as in several of the analysed cases it never progressed towards the actual conference or that during the

[3] This is a shortened version of a commentary that is currently under review by the journal Families in Society (Schout & De Jong, n.d.).

conference conflicts broke out subsequently leading to an abrupt cancellation of the conference. This could probably have been prevented when attention was paid to potential risks during the preparatory stage. Coordinators could benefit from feedback given by clients, their social network and professionals, especially, as we will outline below, when there is a lack of initiative.

Breaking through a lack of initiative in client systems is related to gaining trust and building a relationship with people who lack confidence in themselves, in the future and in the institutional system (Schout *et al.*, 2010; 2011). The quality of a working relationship is enhanced by asking open questions like: *How do you think I am doing?* and *What do you think of the way we are working together?* Or by a closed question such as: *Are we doing the right things in the right manner?* According to Hermanns (2008), working effectively means organising feedback on the functioning of help being offered according to the family. International studies show that collecting feedback of clients has positive effects on treatment outcomes (Baert, 2011). In psychotherapy, there is a lot of experience and knowledge in systematically gathering feedback on the purpose, nature and progress of treatments. This also correspondents with Tronto's (2009) ideas of ethical nursing: responsiveness is a virtue of good care. Lambert *et al.* (2001) argue that patients whose treatment is likely to fail, remain longer in therapy if the therapist exchanges feedback than when a therapist does not do so. Feedback on the progress of clients leads to adjustments of the treatment that in turn improves results, even when therapists operate without formal instructions (Duncan *et al.*, 2004; Reese *et al.*, 2009; Shimokawa *et al.*, 2010; Whipple & Lambert, 2011). The beneficial effect of systematically collecting feedback is specifically paramount for clients whose poor outcome is expected (Whipple *et al.*, 2003). Especially the client group of PMHC – a group where poor outcomes in particular are expected – could benefit from feedback on process and results. Systematically collecting feedback on the relationship and (the lack of) progress helps in gaining trust or regaining it when it is lost.

In the Netherlands and other countries, a FGC coordinator is an independent citizen who assists a fellow citizen in establishing a plan. Is systematically collecting feedback a form of wanted or unwanted professionalisation? Is it inevitable that coordinators professionalise or does it undermine the fundamentals of FGC? Our study indicates that the position of a fellow citizen who is free of interests works well with the PMHC client group. On the other hand, coordinators may benefit from collecting feedback in cases where paralysis and a lack of initiative are imminent. A trained volunteer who is aware of this delicate balance is probably the best of both worlds: a civil actor who is able to organise feedback.

What is advisable for FGC coordinators, is building a certain degree of sensitivity. In the one situation it is recommendable to motivate clients for inviting certain people for the conference, while in the other situation it is better to share doubts on the possible composition of the participants. Coordinators should weigh between asking a question such as *What do you need so your family will take part in the conference?* and when it is better to leave such a question aside. In the cases that yielded successful plans coordinators chose for putting the client in charge for inviting potential participants, but also motivated them to reflect on whether it was wise to ask certain people to join or not.

The FGC coordinator is a potential bridge between the civil and professional society. To establish contact and gain trust of a client group that is characterised by suspicion and mistrust, tenacity is required. A personal 'click' with clients plays a vital role. The following competencies and characteristics are important: empathy, the courage to depart from beaten tracks, flexibility, being easily accessible, and the ability to deal with shocks and uncertainties. In a former study we carried out, we indicated that professionals who were most successful in making contact and gaining trust with the PMHC client group possessed these skills (Schout *et al.*, 2010)

The role of professionals is not to be ceased

The role of professionals in the FGC process and their influence, especially during the preparation of the conference and implementation of the action plan, should not be overlooked. With the policy transformations on social welfare, youth care and long-term care in the Netherlands, there is a need to rethink professional interventions. Increasingly professionals are urged to deploy social network strategies. This requires a different professional attitude and a task perception that changes into what Gerritsen (2013) describes as "egoless care": professionals who enjoy making themselves redundant and who give the social network the feeling that they solve the problems themselves.

What is needed in this new social welfare era is a professional who creates situations in which clients are not only postulated as the owners of their problems, but also as the owners of the potential solutions. Though, discovering, appealing and encouraging the strengths and the virtues should not be accompanied by downplaying clients' impairments and disabilities. The language of FGC is strongly focused on capabilities and opportunities, but a valid question is whether defects and disorders are not too extensively swept under the mat and overlooked. On the other hand, professionals should resist the temptation to organise individual care trajectories when FGC plans (are likely to) fail.

Involving support from social networks and thinking in terms of strengths and capabilities demands a different professional culture with another language and vocabulary. It is therefore a fundamental challenge to describe the role of professionals in the different stages of FGC, and how they can be of support to clients and their network. In the most successful cases of our study, we have observed that when a collaboration between coordinators and professionals was initiated, both were consequently able to benefit from each other's qualities. We have seen that professionals often had a good relationship with clients, but had little insight into their network. FGC coordinators were thus easily accepted and trusted by clients, while professionals benefitted from the coordinators' qualities to think in terms of 'widening the circle' and creatively mobilising possible resources they had never thought of themselves.

The FGC coordinator is not there to replace professionals. They can complement each other and subsequently prepare a conference with the potential best outcome.

General conclusion

Slightly more than half of the analysed family group conferences (n=23, 56.1%) can be considered successful as a plan was established and goals afterwards achieved. The perceived resilience of PMHC client(system)s was reinforced after the conference. However, the increase in their perceived capabilities and self-reliance was not spectacular. Their perceived living situation improved, albeit limitedly. As both the quality and quantity of the social support increased according to the participants, we can state that the conferences had a positive impact on increasing help from informal resources. The caseload of professionals did decrease a bit, but in most cases professionals remained involved. This, however, is not a negative sign as connecting with and trusting professionals is actually a main goal in PMHC. It is, however, remarkable that in the group conferences with a successful outcome, we have observed a less demand for care: professionals in these cases indicated that after the conferences they were significantly less frequently involved with the situation than before.

Given the characteristics of the study population, these results are modest but also promising. That the outcomes were not more significant can be explained. The clients referred to our study often had a unilateral network (barely weak ties) and few social resources from who support could be expected. FGC helped in recovering contacts, but widening the circle was difficult to achieve. Many clients did not want to hang out the dirty laundry and preferably chose a route to professional care where same degrees of shame are usually not evoked.

The qualitative analysis of the successful and apparently failed conferences foregrounded seven clues that shed light on the process of FGC in PMHC:

1. The complexity and multiplicity of the problems of the PMHC client group require the intelligence and capabilities of a large and diverse group of family members, friends and concerned bystanders. In PMHC it is likely that a kitchen-table-conversation alone will not produce the progress that is needed. The solutions that in a family group conference emerge are also in line with the culture (norms and values) of the extended family and community itself.
2. Shame works as a protective factor. Clients do not want to feel embarrassed again so they do not relapse in old destructive patterns. They also do no longer want to be faced with the misery they have caused to others and the grief that accompanies it. This too has a preventive function.
3. A significant part of the study population does not want to change for professionals, but they will do for family, friends and even, as we have described in Chapter Six, former colleagues. These actors can choose positions and use words professionals cannot use, but that are often needed to let clients realise their unacceptable behaviour and consequently change it.
4. Being embedded in a social network reduces vulnerability, as well as the risk of relapse, and therefore decreases the threat of coercive measures (Chapter Seven).
5. FGC provides a platform for discussing conflicts and consequently restoring relationships. A platform whereon the client dares to discuss shameful feelings and the social network has the chance to express its concerns and dissatisfaction towards the client. In addition, this platform helps breaking through the embarrassment to ask for and provide help.
6. The sustainability of FGC plans depends on whether reciprocity is triggered and whether there is a strong person within the network or a professional who is able to keep everyone on the right track, and to foster the implementation of the plan.
7. The analysed group conferences on neighbourhood conflicts where PMHC clients were involved proved that a successful conduct is within reach when both the troublemakers and those who are affected by their unacceptable behaviour participate and establish a plan together which is reviewed by professionals on safety and efficacy issues (Chapter Eight).

On the basis of our study we can conclude that social isolation, rather than being a contra-indication, is an important reason for organising FGC, precisely because of its potential to create conditions for restoring contact and social embedding.

Remarkably, the group conferences on liveability problems proved to generate sustainable outcomes in the long run while participants were initially sceptical on their course. Of the six cases in which the conferences positively impacted the living conditions within the neighbourhood, one year after they were organised the situation remained stable and liveable. Again, shame did have a preventive effect here: apparently those concerned no longer wanted to end up in an arena of conflicts and justify themselves to a large group once again. In addition, the involvement of professionals in these cases significantly decreased: as the civil society was able to correct itself, it was no longer necessary the professional society should do so.

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